Advanced Practice Registered Nurse Coalition Testimony on SB 2
February 5, 2013

Good morning Senator Jansen and members of the committee. Thank you for this opportunity to speak in support of Senate Bill 2. First I would like to introduce my colleagues: Ms. Cathy Lewis, a clinical nurse specialist and a director of MI-CNS organization and Ms. Barbara Lannen, a certified nurse midwife; they will be happy to answer any questions regarding their specific APRN role, following my testimony. My name is Nancy George, and I have been a Nurse Practitioner for over 20 years in primary care, in the state of Michigan. I have practiced primarily in nurse-managed centers affiliated with Wayne State University College of Nursing, and the University of Michigan. I am also an assistant professor of nursing and the assistant director of the Doctor of Nursing Practice program at Wayne State University, College of Nursing, the current President of the Michigan Council of Nurse Practitioners, and the Chair of the APRN Coalition of Michigan. I am honored today to represent the 4,700 Nurse Practitioners, unknown number of Clinical Nurse Specialists and 277 Certified Nurse Midwives of Michigan. My comments today will address how Senate Bill 2 would allow these advanced practice registered nurses to reduce the cost, improve the quality and access to health care for the citizens of Michigan, and drive economic development throughout the state.

As you may know, Advanced Practice Registered Nurses have a bachelor's of science degree in Nursing, hold a valid Registered Nursing license, go on to complete a nationally accredited graduate or doctoral nursing program, and take a national certification exam following completion of their schooling to obtain a specialty certification as an nurse practitioner or certified nurse midwife in the state of Michigan. Currently, clinical nurse specialists are not recognized in Michigan statute, although they are one of the oldest advance practice registered nursing specialties. Nurse practitioners, clinical nurse specialists and certified nurse midwives are educationally prepared to provide a variety of services across the health wellness-illness continuum to at least one of six population foci: family/individual across the lifespan, adult-gerontology, pediatrics, neonatal, women's health/gender-related or psych/mental health; please note that the emphasis and implementation within each role varies. The services are not defined or limited by setting, but rather by patient care needs. However, the emphasis and implementation varies across the nurse practitioner, clinical nurse specialist, and certified nurse midwife role. Licensure and autonomous practice authority are based on graduate education in one of the defined roles and population foci. A nurse practitioner, clinical nurse specialist, and certified nurse midwife must have extensive clinical experience, and have acquired advanced clinical knowledge and skills preparing her/him to provide direct care to patients.

A nurse practitioner, clinical nurse specialist, and certified nurse midwife accepts responsibility for health promotion and risk reduction, as well as the assessment, diagnosis and management of patient problems including the administration and prescription of pharmacologic and non-pharmacologic interventions. Advanced Practice Registered Nurses provide healthcare services in a variety of settings and are qualified to meet the majority of patients' health care needs. Advanced Practice Registered Nurses are educated and trained to evaluate and treat a

multitude of acute and chronic health problems, focusing on teaching patients self-care techniques to improve their quality of life and reduce health care dollars spent by decreasing recurrence and exacerbation of their illnesses.

Some examples of health care services provided by APRNs are completing comprehensive health histories and physical exams, diagnosis and treatment of acute problems such as infections and injuries, diagnosis, treatment and management of chronic problems such as asthma or diabetes, routine care such as prenatal, well child-care, preventive adult care, ordering and interpreting lab tests, x-rays and other diagnostic studies, preventive health guidance and counseling.

Even though Michigan has over 5,000 nurse practitioners, clinical nurse specialists and certified nurse midwives practicing in the state of Michigan, the need for primary care is going to increase significantly over the next decade. The U.S. lacks sufficient primary care providers in many parts of the country, including Michigan. Michigan alone will have a shortage of 4,400 primary care physicians and 4,000 specialty physicians by 2020. Currently, only 36% of active physicians in our state practice primary care. In Michigan, 48% of physicians surveyed by the Michigan Department of Community Health had nearly full practices, and approximately 11% of physicians no longer accepted new patients due to maximum patient capacity. To add further to the woes of physicians entering primary care, there is a looming bottleneck of residency slots, which the is controlled by the Federal government and graduate medical education funding and slots are being dramatically cut. At the same time the number of nurse practitioners being educated as primary care providers continues to increase geometrically each year. Clinical education programs for Advance Practice Registered Nurses do not receive Federal Graduate Medical Education funds, therefore, the cuts to this funding does not impact nurse practitioner, clinical nurse specialist, and certified nurse midwife clinical experiences. However, growth of the nursing workforce is hampered by outdated, ambiguous state regulations.

The problem is that Michigan's regulatory environment creates barriers for APRNs to provide health care to the full scope of their education and certification. Current regulations are vague and discourage graduating APRNs from remaining in Michigan to practice and limit the role of many who do work here. While there are a variety of reasons Advanced Practice Registered Nurses or other providers choose to get their education and training in Michigan but then leave the state to practice somewhere else, has been linked to Michigan's ambiguous and restrictive practice environment. Keeping our highly trained and qualified Advanced Practice Registered Nurses in our state will spur job growth and retention and help alleviate the looming primary care shortage Michigan is facing. It is a fact that states with less restrictive regulatory environments have higher numbers of health professionals for their patient population.

States that have a favorable regulatory environment have an improved nurse practitioner to patient ratio. Currently, Michigan's ratio of nurse practitioner to patient is 30:100,000 making us lower than the national average of 54:100,000. This ratio ranks MI 47th out of 50 states and the District of Columbia. States with less restrictive regulatory environments have higher ratios. For example, Vermont is 84:100,000. North Dakota is 63:100,000. Arizona is 54:100,000 all states with full autonomous practice authority. Having an excellent practice environment goes a long way to creating a nurse friendly state that attracts and retains our brightest and finest nurse practitioners.

Advanced Practice Registered Nurses, including certified nurse midwives, clinical nurse specialists and certified nurse practitioners are highly valued providers of health care services and an integral part of the health care system. The passage of the federal Patient Protection Affordable Care Act exacerbates the growing need for experienced health care professionals. Expansion of coverage creates an increase in demand for qualified health care providers. Currently, there is no uniform model of regulation for Advanced Practice Registered Nurses in Michigan or across state jurisdictions, which has created a significant barrier for Nurse Practitioners, Clinical Nurse Specialists and Certified Nurse Midwives to meet the increasing demand as health care providers, especially in rural and low-income areas. Senator Jansen's SB 2 has been modeled after what other states have already done to address access to care issues. In many other states the regulatory framework has evolved in step with Advanced Practice Registered Nurses expanding skills, education, training, and abilities.

> For example in Idaho, New Mexico or Vermont where a nurse practitioner can practice with full autonomous practice authority, order and interpret laboratory and other tests, diagnose and treat illness and injury prescribe indicated drugs, order or refer for additional services, admit and attend patients in a hospital or other facility and get paid directly for her services. When this same NP moves to Michigan however, it is as if her competence has suddenly evaporated, she has unclear regulation, she will need delegated prescriptive authority so her name isn't on the mediation label, and she can no longer order physical therapy, or speech therapy.

Sixteen states and the District of Columbia have already granted full plenary authority for Advanced Practice Registered Nurses, similar to the language in Senate Bill 2. That means Advanced Practice Registered Nurses practice under their own license and are accountable for the care they deliver. For example, New Mexico has had autonomous practice authority for its Advanced Practice Registered Nurses for over 20 years without negative implications for the citizens or their physician colleagues practice. North Dakota allows for autonomous practice and a collaborative agreement requirement for full prescriptive authority was eliminated through legislation, in 2011. Since 1993, Maine has allowed their Advanced Practice Registered Nurses to practice without a written collaborative

agreement or supervision. Vermont has had autonomous practice for over 18 years, and their statute is very similar to that of Senate Bill 2. Autonomous practice authority does not mean Advanced Practice Registered Nurses will not or do not collaborate with other health professionals. Rather, Advanced Practice Registered Nurses like other health professionals, practice under our own license and are accountable for their care they provide. Collaboration is viewed as a professional ethic for every licensed health care provider including Advanced Practice Registered Nurses, physicians, physician assistants, and pharmacists--and one that cannot be regulated in statue.

Michigan is one of the few states without a defined practice authority for advance practice registered nurses in its Public Health Code. This lack of a definition leaves heath care systems or other organizations without a clear idea of what kind of care these advanced practice nurse practitioners can 'legally' provide autonomously. Vague guidelines have caused uncertain interpretation of state law and created a challenging practice environment that does not allow all Nurse Practitioners, Clinical Nurse Specialists and Certified Nurse Midwives to practice to their full capabilities based on their education, training and national certification.

To address these discrepancies, the National Council of State Boards of Nursing, along with 48 other national organizations, developed model language that is reflected in Senate Bill 2. Senate Bill 2 meets the gold standard set by the National Council of State Boards of Nursing model language goals of regulation. Specifically, Senate Bill 2 would:

1. Allow an advanced practice registered nurse to provide health care services within their defined practice authority for which they are educationally and experientially prepared;
2. Requires consultation or referral of patients, as appropriate;
3. Define the practice authority for Clinical Nurse Specialist-Certified, Certified Nurse Midwives, or Certified Nurse Practitioners;
4. Replaces specialty certification with a license to a certified nurse practitioner, clinical nurse specialist-certified, and certified nurse midwife which is contingent upon completion of an accredited graduate-level education program and passage of a national certification examination;
5. Allows the state Board of Nursing to create rules for the application renewal and number of continuing education hours/courses for Advanced Practice Registered Nurses;
6. Creates an APRN taskforce with members from their current Board of Nursing, which will consult with the full board on the disciplinary actions for Advanced Practice Registered Nurses, and;
7. Grants full prescriptive authority for certified nurse practitioners, clinical nurse specialists-certified, and certified nurse midwives if certain conditions are met, which include:
    a. the completion of graduate level pharmacology, pathophysiology and physical assessment courses, clinical experiences specified

within their specialty role and a specified contact hours in pharmacology;
   b. the possession of a specialty prescriptive certification and a controlled substance license issued by the Michigan Department of Community Health;
   c. APRNs with less than 2 years of experience would have to participate in a mentorship program with an autonomous prescriber before full authority is granted.
8. Require all APRNs to provide information about the controlled substance prescriptions for each controlled substance prescribed to the Michigan Department of Licensing and Regulatory Affairs for submission to the Michigan Automated Prescription System program. Advanced Practice Registered Nurses would be the first health profession to be mandated by statute to do this.

What Senate Bill 2 does not change is statute language regarding third-party reimbursement, nor does it mandate reimbursement rates from insurers or dictate employment agreements. Simply stated, this legislation would allow APRNs to improve cost, quality and access to health care for the citizens of Michigan.

Recently, there have been several studies that highlight the need to end barriers to Advanced Practice Registered Nurses practice. The key message from recent reports published by the Josiah Macy Foundation and the Institute of Medicine; is that Advanced Practice Registered Nurses should practice to the full extent of their education and training. Specifically that changing scope-of-practice regulations, should allow for nurse practitioners to "*see patients and prescribe medications without*" regulatory barriers. This identified reduction of barriers has been supported by several other organizations including the National Council of State Boards of Nursing, National Health Policy Forum, American Association of Retired Persons, Citizen Advocacy Center, and Coalition for Patients Rights.

Further, a recent policy brief from Rand Health, addressed the rising cost of health care in Massachusetts after enacting the near universal health plan. The policy brief made multiple recommendations including encouraging policies that would promote nurse practitioner practicing to their fullest preparation without unnecessary regulations. They went on to say that nurse practitioners are underutilized despite being qualified to provide primary care at a lower cost than other providers. The American Association of Colleges of Nursing estimated that the underutilization of nurse practitioners costs the United States $9 billion annually. A recent economic analysis found that greater use of Advanced Practice Registered Nurses would result in 97,205 new permanent jobs, $8 billion in annual economic output and $16.1 billion in total expenditures per year within the state of Texas, alone.

Nurse practitioners, and certified nurse midwives typically prescribe fewer drugs, order less expensive tests, and use lower cost treatment, at comparable or better quality treatment than other health care providers. A study in Tennessee found that costs at nurse managed clinics were 23% below the costs of care delivered by other primary care providers; further, they had a 21% lower inpatient hospitalization rate, 25% lower utilization of laboratory test below other primary care providers; and a 42% prescription drug order rate well below average.

What does this mean in actual dollar savings? Well, a recent study showed infants cared for by Neonatal Nurse Practitioners average 2.4 fewer days in the hospital which saved between $3,400-$18,000 in total hospital charges, per patient. A large corporation in North Carolina housed an on-site health care clinic run by nurse practitioners for their employees and had an annual cost savings of over $1.3 million yielding a benefit to cost ratio of 15 to 1. A study conducted by the Florida state government estimated regulatory changes that would reduce practice barriers and increase utilization of nurse practitioners and other health care providers could provide a cost savings of $7 million to $44 million annually for Medicaid, up to $2.2 million for state employee health insurance annually, and a total of $339 million in savings annually across Florida's healthcare system. A list of additional articles and research on the quality and cost effectiveness of Advanced Practice Registered Nurses services is available upon request.

In closing I would like to note that many state and national organizations, including the Macy Foundation, PEW, the Institute of Medicine, and the Rand Reports concur that removal of autonomous practice authority barriers can improve primary care quality and efficiency of care and all primary care providers should be held accountable for the quality and efficiency of care as measured by patient outcomes. Please support SB 2, is gold standard practice language moving Michigan into the top of 50 states as opposed to the bottom where we now reside. Again, thank you for this opportunity to present to you. My colleagues and I are happy to answer any questions you may have.

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APPENDIX

Certified Nurse Practitioner (CNP)
Currently, there are over 4,700 nurse practitioners in Michigan. For a CNP, care along the wellness-illness continuum is a dynamic process in which direct primary and acute care is provided across settings. CNPs are members of the health delivery system, practicing autonomously in areas as diverse as family practice, pediatrics, internal medicine, geriatrics and women's health care. CNPs are prepared to diagnose and treat patients with undifferentiated symptoms, as well as those with established diagnoses. Both primary and acute care CNPs provide initial, ongoing, and comprehensive care, including taking comprehensive histories, providing physical examinations, and other health assessment and screening activities, and diagnosing, treating, and managing patients with acute and chronic illnesses and diseases. This includes ordering, performing, supervising, and interpreting laboratory and imaging studies; prescribing medication and durable medical equipment; and making appropriate referrals for patients and families. Clinical CNP care includes health promotion, disease prevention, health education and counseling, as well as the diagnosis and management of acute and chronic diseases. CNPs are prepared to practice as primary care CNPs and/or acute care CNPs, which have separate national consensus-based competencies and separate certification processes.

Clinical Nurse Specialist (CNS)
A CNS is a unique advanced practice registered nurse role that integrates care across the continuum and through three spheres of influence: patient, nurse and system. The three spheres are overlapping and interrelated, but each sphere possesses a distinctive focus. The primary goal of a CNS is continuous improvement of patient outcomes and nursing care. Key elements of CNS practice are to create environments through mentoring and system changes that empower nurses to develop caring, evidence-based practices to alleviate patient distress; and facilitate ethical decision-making. A CNS is responsible and accountable for diagnosis and treatment of health/illness states, disease management, health promotion, and prevention of illness and risk behaviors among individuals, families, groups and communities.

Certified Nurse-Midwife (CNM)
A CNM provides a full range of primary health care services to women throughout the lifespan, including gynecologic care, family planning services, preconception care, prenatal and postpartum care, childbirth, and care of a newborn. The practice includes treating the male partner of their female clients for sexually transmitted disease and reproductive health. This care is provided in diverse settings, which may include home, hospital, birth center and a variety of ambulatory care settings, including private offices, and community and public health clinics.